DEPARTIMENT OF HEALTH AND HUMAN SERVICES No. 72547RINP. 2 11/14/2011 FUKIN APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445174 11/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2036 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) **INITIAL COMMENTS** F 000 F 000 An annual Recertification survey was completed on November 7-9, 2011 with an Extended survey completed on November 8, 2011. The facility failed to administer the facility in a manner to maintain the the safety of the residents by ensuring the fire sprinkler system was in a reliable operating condition. The facility was cited with an Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death). The Administrator was notified of the Immediate Jeopardy on November 7, 2011, at 4:00 p.m. in the Administrator's office. The Immediate Jeopardy for tags K-62, K-154, and F-490, at scope and severity levels of an "L", were effective from October 10, 2011, through November 8, 2011. On November 8, 2011, the facility provided an acceptable allegation of compliance lowering the Immediate Jeopardy. The scope and severity for K-62, K-154, and F-490, were lowered to an "F" level. Complaint investigation #28827 was completed during the annual recertification survey on November 7 - 9, 2011. No deficiencies were cited related to the complaint investigation #28827 under 42 CFR Part 483, Requirements for Long Term Care Facilities. F 221 483.13(a) RIGHT TO BE FREE FROM F 221 PHYSICAL RESTRAINTS \$\$=D The resident has the right to be free from any physical restraints imposed for purposes of LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Admin istrat

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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/14/2011

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in the second se	discipline or conveit treat the resident's  This REQUIREMENT by: Based on medical and interview the fat from restraints for otwenty-seven resident #14 was a 20, 2010, with diagram, History of Famur, History of	nience, and not required to medical symptoms.  NT is not met as evidenced record review, observation, icility falled to ensure freedom one resident (#14) of ents reviewed.  ed:  idmitted to the facility on July noses including Fracture alls, and Difficulty Walking.  ew of the Minimum Data Set mber 13, 2011, revealed the tensive assistance with	F 221	F 221 Corrective action(s) accomplished a residents found to have been affected. Resident #14 on November 08, 2011: received an order clatification to D\C and have lap buddy in wheelchair.  How other residents having the potential be affected were identified and correction(s) accomplished:  Restorative Aid on November 15, 2011 all residents with restraint orders for correstraint placement and type.  Measures or systematic changes put place to ensure the deficient practice recur:  Beginning on November 7, 2011 and on Licensed Nurses and Certified Nursing Assistants were educated by the Direct Nursing and/or Assistant Director of Nursing and ensure deficient practice will be added to the employed orientation packet.  Quality Assurance program put into monitor corrective actions and ensure deficient practice will not recur:  Beginning on November 15, 2011, the restorative aid or designee as determined Director of Nursing will do checks of reto ensure the correct restraint is in place times a week for ninety days with month submission to the Quality Assurance Cowho will determine the need for future for The Director of Nursing or Assistant Director of Nursing will report findings in the Quality Assurance Committee meeting (made up Assurance Committee me	for those ed:  LPN soft waist  ential to ective  I checked orrect  into edos not engoing for of ursing to on a e e the ethe ethe ethe ethe ethe ethe	11/21/2011
re	estraint in place.	nad an unnecessary		Medical Director, Administrator, Director Nursing, Assistant Director of Nursing, F Manager, etc.)	r of Risk	

DISCOULD FEB HIMNON P. 4 No. /254 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/14/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING B, WING 445174 11/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2035 STONEBROOK PLACE KINGSPORT, TN 37660 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 241 483.15(a) DIGNITY AND RESPECT OF F 241 F 241 SS=D INDIVIDUALITY Corrective action(s) accomplished for those The facility must promote care for residents in a residents found to have been affected: 11/21/2011 manner and in an environment that maintains or enhances each resident's dignity and respect in Resident #16 on November 8, 2011: Certified full recognition of his or her individuality. Nursing Assistant provided a bath blanket, dried, and dressed resident. This REQUIREMENT is not met as evidenced How other residents having the potential to by: be affected were identified and corrective Based on medical record review, observation, action(s) accomplished: and interview the facility falled to provide privacy On November 8, 2011 Certified Nursing during ADL (Activities of Daily Living) care for one Assistants working the shower rooms were resident (#16) of twenty-seven residents educated by the Assistant Director of Nursing reviewed. on keeping residents covered in the shower room. The findings included: Resident #16 was admitted to the facility on April Measures or systematic changes put into 8, 2011, with diagnoses including Hypertension, place to ensure the deficient practice does not Encephalopathy, Dementia, and Chronic Obstructive Pulmonary Disease. Beginning on November 9, 2011 and ongoing Certified Nursing Assistants were educated by Medical record review of the MDS (Minimum Data the Director of Nursing and/or the Assistant

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dress the resident.

Set) dated September 25, 2011, revealed

resident #16 was completely dependent on staff

for all ADL care, including hygiene and bathing.

Random observation on November 8, 2011, at

shower room, with CNA #1 and CNA #2 in

attendance. Resident #16 had just been showered and was in a shower chair, unclothed

and uncovered, shivering and visibly

10:40 a.m., revealed resident #16 in the 400 hall

uncomfortable, as CNA #1 dried, and prepared to

Continued observation revealed resident #17, in a

Event ID: 8J5F11

Facility ID: TN8203

Director of Nursing on keeping residents

Beginning on November 9, 2011 and ongoing Licensed Nurses and Certified Nursing

on resident rights to include the right to dignity,

Assistants were educated by the Director of Nursing and/or the Assistant Director of Nursing

In services will be added to the employee

covered in the shower rooms.

privacy, and respect.

orientation packet.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/14/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445174 NAME OF PROVIDER OR SUPPLIER 11/09/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BROOKHAVEN MANOR 2035 STONEBROOK PLACE KINGSPORT, TN 37660 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 241 Continued From page 3 F 241 F 241 cont. wheelchair, present in the shower room, awaiting a shower, and sitting within two feet of the fully Quality Assurance program put into place to exposed resident #16. monitor corrective actions and ensure the deficient practice will not recur: Interview with CNAs #1 and #2 confirmed that resident #16 was fully exposed, in front of Beginning on November 21, 2011, The resident #17, and his right to privacy and dignity, Assistant Director of Nursing or Risk Manager will make observations of showers two times a during care, had not been respected. week for four weeks to ensure residents are being provided privacy, and treated with dignity Interview with LPN #1, the 400 hall Unit Manager, and respect the findings will be reported to the confirmed resident #16 had been unnecessarily Quality Assurance Committee who will exposed, and his privacy and dignity, during care, determine the need for future focus. had not been respected. The Assistant Director of Nursing or Risk F 257 483.15(h)(6) COMFORTABLE & SAFE Manger will report overall findings in the F 257 TEMPERATURE LEVELS SS=D Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, The facility must provide comfortable and safe Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.) temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F F 257 Corrective action(s) accomplished for those This REQUIREMENT is not met as evidenced residents found to have been affected: by: 11/21/2011 Resident #20 on November 8, 2011: Based on medical record review, observation, Maintenance removed lock from resident's and Interview, the facility failed to provide a heating unit. comfortable temperature level for one resident (#20) of twenty-seven residents reviewed. How other residents having the potential to be affected were identified and corrective The findings included: action(s) accomplished: Resident #20 was admitted to the facility on On November 8, 2011 all resident rooms were November 5, 2009, with diagnoses including checked by Maintenance for locks on heating units and any found were removed. Peripheral Vascular Disease, Parkinsons, and

Hypertension.

Medical record review of the Minimum Data Set (MDS) dated September 14, 2011, revealed the

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STATEMEI AND PLAN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445174		(X2) MULTI A. BUILDIN B. WING _		(X3) DATE COMP	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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F 282 SS=D	resident scored a f Mental Status (BIM decisions.  Observation on No in the resident's rod on the bed dressed "I'm cold."  Observation on No in the resident's rod on the bed dressed "I'm cold and they is observation reveale unit.  Interview with the M November 8, 2011, room, revealed the is degrees and the residenterature to be so Interview with the Ni November 8, 2011, Service Director office failed to provide a co for the resident and it 483.20(k)(3)(ii) SERV PERSONS/PER CAF The services provided must be provided by accordance with each care.	ifteen on the Brief Interview for IS) and is able to make daily vember 7, 2011, at 11:10 a.m., om, revealed the resident lying with a jacket on and stated, owember 8, 2011, at 3:10 p.m., om, revealed the resident lying with a jacket on and stated, owember 8 with a jacket on and stated, owember 8, 2011, at 3:10 p.m., om, revealed the resident lying with a jacket on and stated, owember 8, 2011, at 3:10 p.m., om, revealed the resident lying with a jacket on and stated, owember 8, 2011, at 3:10 p.m., om, revealed the resident lying with a jacket on and stated, owember 8, 2011, at 3:10 p.m., on the resident lying with a jacket on and stated, owe lated the resident lying with a second the second the social confirmed the facility of the lock would be removed.  VICES BY QUALIFIED RE PLAN	F 282	F 257 cont.  Measures or systematic changes puplace to ensure the deficient practice.  Beginning on November 8, 2011 the Maintenance Director or Maintenance will make monthly checks of resident ensure no units have had locks placet will be for six months with monthly sto the Quality Assurance Committee determine the need for future focus.  Quality Assurance program put intended the practice will not recure.  The Maintenance Director or Maintent Assistant will report overall findings in Quality Assurance Committee Meetin consists of the Medical Director, Adm Director of Nursing, Assistant Director Nursing, Risk Manager, etc.)	e Assistant t rooms to f. Checks submission who will to place to ure the tance in the g (which		

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99±D	Based on medical and interview, the ficare plan for one (# reviewed.  The findings include Resident #2 was as 2011, with diagnose Atrial Fibrillation, Di Obstructive Pulmon Medical record revie on October 20, 201 skin breakdown d/t incontinent of B&B (diagnosis) of diabe Observations on No November 8, 2011, 9, 2011, at 9:00 a.m was present on the observation on Nove with the Director of Mying on the bed. Co a skin assessment viewer no areas of ski Interview on November 1, 2011, at 9:00 a.m was present on the director of November 1, 2011, at 9:00 a.m was present on the director of November 1, 2011, at 9:00 a.m was present on the director of November 1, 2011, at 9:00 a.m was present on the director of November 2, 2011, at 9:00 a.m was present on the bed. Co a skin assessment viewer no areas of ski Interview on November 3, 25(d) NO CATHIRESTORE BLADDE	record review, observation, acility failed to implement the #2) of twenty-seven residents  add:  dmitted to the facility on July 8, as including Pneumonitis, abetes, and Chronic hary Disease.  ew of the Care Plan reviewed 1, revealed "Potential for (due to) difficulty with mobility, (bowel and bladder), dx tesAir mattress"  evember 7, 2011, at 3:20 p.m., at 9:40 a.m., and November 1, revealed no air mattress resident's bed.  ember 9, 2011, at 9:55 a.m., Nursing, revealed the resident entinued observation revealed was completed and there in breakdown.  per 9, 2011, at 9:55 a.m., with ng, in the resident's room, at tress was not applied to the effect of the e	F 315	Corrective action(s) accomplish residents found to have been aff Resident #2 on November 09, 201 mattress applied to bed by the cenclerk.  How other residents having the be affected were identified and caction(s) accomplished:  On November 16, 2011 the wound checked all residents with an order mattress to ensure mattress was in Measures or systematic changes place to ensure the deficient practice.  Beginning on November 16, 2011; care nurse or Risk Manager will maked to the checks of residents with orders for once a month and when a new order for one year with monthly submiss. Quality Assurance committee who determine the need for future focus.  Quality Assurance program put it monitor corrective actions and endeficient practice will not recur:  The Director of Nursing or the Risk will report the overall findings in the Assurance Committee Meeting (who of the Medical Director, Administrator Nursing, Assistant Director of Nursing of Nursing, Assistant Director of Nursing, Assistant Director of Nursing of Nursing, Assistant Director of Nursing of Nurs	potential to corrective  care nurse for an air place.  put into the wound ake random air mattresses it is received ion to the will  nto place for sure the will  Manager e Quality into Director. Director	11/21/2011
99±D	Based on the resider	R	F 315	of Nursing, Assistant Director of Nu	rsing, Risk	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/14/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY GOMPLETED A BUILDING B. WING 445174 11/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2035 STONEBROOK PLACE KINGSPORT, TN 37660 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 315 Continued From page 6 F 315 resident who enters the facility without an indwelling catheter is not catheterized unless the 11/21/2011 Corrective action(s) accomplished for those resident's clinical condition demonstrates that residents found to have been affected: catheterization was necessary; and a resident Resident #2 on November 08, 2011; L.P.N. who is incontinent of bladder receives appropriate completed a bowel and bladder assessment and treatment and services to prevent urinary tract started a B&B plan. infections and to restore as much normal bladder function as possible. How other residents having the potential to be affected were identified and corrective action(s) accomplished: This REQUIREMENT is not met as evidenced On November 14, 2011 the Unit Managers by: began checking all resident's charts to ensure Based on medical record review, observation, bowel and bladder assessments were complete and interview, the facility failed to complete a and plans started per policy. All chart checks bladder assessment and develop a bladder will be completed by November 21, 2011. retraining program for one (#2) of twenty-seven residents reviewed. Measures or systematic changes put into place to ensure the deficient practice does not recur: The findings included: Beginning on November 14, 2011 the Unit Resident #2 was admitted to the facility on July 8, Managers or Risk Manager will make random 2011, with diagnoses including Pneumonitis, checks of bowel and bladder assessments to ensure completion and plans have been started Atrial Fibrillation, Diabetes, and Chronic per policy. The checks will be done two times a Obstructive Pulmonary Disease. month for six months with monthly submission to the Quality Assurance Committee who will Medical record review of the Minimum Data Sets determine the need for future focus. dated July 17, 2011, and October 12, 2011, revealed the resident was incontinent of bladder. Quality Assurance program put into place to monitor corrective actions and ensure the Medical record review of an undated and 4.3.5 2.5.1.5.00 deficient practice will not recur: unsigned Bladder Incontinence Evaluation revealed the resident was alert, followed The Director of Nursing or the Risk Manager directions, and had daily incontinent episodes will report overall findings in the Quality with some control. Continued review of the Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director Bladder Incontinence Evaluation revealed the of Nursing, Assistant Director of Nursing, Risk section for Evaluation for Bladder Program Manager, etc.)

Potential had not been completed.

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PRINTED: 11/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 446174 11/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2035 STONEBROOK PLACE KINGSPORT, TN 37860 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX COMPLETION DATE PREFIX TAG TAG DEFICIENCY) Continued From page 7 F 315 F 323 Medical record review revealed no documentation a bladder retraining program had been Corrective action(s) accomplished for those 11/21/2011 established for the resident. residents found to have been affected: Interview on November 9, 2011, at 9:30 a.m., with Resident #1 on November 9, 2011; Restorative aid checked bed alarm, alarm working and mats the resident, in the resident's room, revealed the were placed correctly at the bedside by resident had the perception of the need to void. Restorative aid. Interview on November 8, 2011, at 11:00 a.m., Resident #23 on November 15, 2011; LPN with Licensed Practical Nurse #2, in the obtained physician's order for mats at bedside while in bed except when eating. conference room, confirmed the undated and unsigned Bladder Incontinence Evaluation was Resident #12 on November 8, 2011; scathelt not complete and confirmed a bladder retraining was checked immediately by the Assistant program had not been established for the Director of Nursing and functioning correctly. resident. Resident #22 on November 9, 2011; Restorative F 323 483.25(h) FREE OF ACCIDENT F 323 HAZARDS/SUPERVISION/DEVICES aid placed mats at bedside also pressure pad SS=E alarm cord was replaced and in working order. # - ? - Pr 1. The facility must ensure that the resident Resident #3 on November 7, 2011; Certified environment remains as free of accident hazards Nursing Assistant removed soft waist restraint as is possible; and each resident receives and applied correctly. adequate supervision and assistance devices to Resident #14 on November 7, 2011; Certified prevent accidents. Nursing Assistant removed soft waist restraint and applied correctly. On November 16, 2011; Resident's kardex was updated by Licensed Practical Nurse to reflect not to leave resident unattended in restroom. This REQUIREMENT is not met as evidenced How other residents having the potential to Based on medical record review, review of the be affected were identified and corrective manufacturer's recommendations, observation, action(s) accomplished: and interview, the facility failed to ensure safety devices were in place and functioning for five (#1, On November 15, 2011 Restorative nurse aid checked all residents with safety devices to #23, #12, #22, #14) residents, failed to provide

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supervison to prevent an accident for one (#14) resident, failed to implement new interventions after three falls for one (#3) resident, and failed to ensure restraints were applied correctly for two

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Facility ID: TN8203

ensure correct placement.

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	(#3, #14) residents reviewed.  The findings included Resident # 1 was in October 5, 2011, we Fracture Lower End Chronic Obstructive Osteoarthritis, Osteoarthr	ed: eadmitted to the facility on lith diagnoses including femur, Hypertension, e Pulmonary Disease, openia, and Alzheimer's ew of the Minimum Data Set per 13, 2011, revealed the lity impaired cognitive skills, and with transfers. Further evealed the resident had a e nurse's notes, dated vealed "observed resident lying on back, c/o (complaint aln at 10:20 p.m. (October 4, served resident on floor next d to get out of bedbedrails 1) ½ upbed alarm, bed	F3	F 323 cont.  Measures or systematic changes place to ensure the deficient pra recur:  Beginning on November 07, 2011 Licensed Nurses and Certified Nurses and Certified Nursing and/or the Assistant Directon proper soft waist placement with demonstration.  Beginning on November 08, 2011 Licensed Nurses and Certified Nurses and Certified Nurses and Certified Nurses and Nurses and Certified Nursesing and/or the Assistant Directon not leaving residents alone in the that need extensive assistance.  In services will be added to the emporientation packet.  Quality Assurance program put I monitor corrective actions and endeficient practice will not recur:  Beginning on November 15, 2011, restorative aid or designee as determined or Nursing will make rands safety measures to ensure correctne placement. The checks will be done week for ninety days with monthly to the Quality Assurance Committee determine the need for future focus.  The Director of Nursing will report the ofindings in the Quality Assurance Committee of the process of the Med Director, Administrator, Director of Assistant Director of Nursing, Risk 1 etc.)	and ongoing sing irector of Nursing h return  and ongoing sing tor of Nursing h return  and ongoing sing rector of tor of Nursing e restroom  ployee  into place to assure the  the nined by the om checks of ss and two times a submission who will stant verall or mittee ical nursing e local nursing e who will stant verall or mittee ical nursing e local nursing e loca	11/21/201
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DEPAR	NIENT OF HEALTH	& MEDICAID SERVICES			No.	/254RINTP.	1 1/14/2011 PROVED
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4040	PROVIDER OR SUPPLIER		_	203	ET ADDRESS, CITY, STATE, ZIP COD 35 STONEBROOK PLACE NGSPORT, TN 37660	11/0 E	09/2011
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	3:15 p.m., November 2:00 p.m., in the restresident lying on the place to the exit side. Interview with the A (ADON), on Novem the 100 Wing hallwathe bed alarm was reconstructed with RN #2011, when the resistance with RN #2011, when the hed a properly and the alaresident was found 12011. Interview with Licens on November 19, 20 Wing Nurses Station to place the floor main on October 4, 2011, this time.  Resident #23 was read April 12, 2011, with a composite of the place the floor main on October 4, 2011, with a composite of the c	er 8, 2011, at 9:30 a.m. and sident's room, revealed the bed and mats were not in e of bed.  ssistant Director of Nursing ber 9, 2011, at 9:00 a.m., in an and sident's room, revealed the bed not functioning on October 4, dent was found lying in the 2, on November 9, 2011, at isk Manager's office, larm was not positioned rm did not sound when the rying in the floor on October 4, sed Practical Nurse (LPN) #3, 111, at 10:50 a.m., in the 100 a.m., confirmed the facility failed that to the exit side of the bed and the mat is not in place at lagnoses including and the resident that the place in below the Right Knee, alar Disease.  Minimum Data Set (MDS), 2011, revealed the resident term memory deficits and	F	323			

		AND HUMÂN'SERVICES		,		121/14/2011 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		445174	B. WING_		1100	9/2011
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP C		3/2011
	HAVEN MANOR		- 4	2035 STONEBROOK PLACE KINGSPORT, TN 37660		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX . TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	September 25, 2011 revealed the reside no injuries"  Medical record revious control of the reside no injuries"  Medical record revious force assistant) no was in floornurse next to bedc/o (created force) force in floor floor force in floor flo	1, and October 18, 2011, nt had "slid out of bed with ew of a nurse's note dated revealed "CNA (certified tified charge nurse resident observed resident on floor emplaint of) no pain and no s/o ent's Care Plan, last dated revealed "blue mats at commentation, dated October "interventions: high low bed, is (head of bed), blue mats at employed with the head of the bed, are floor.  Vation with Certified Nurse, on November 8, 2011, at 0 Wing hallway, confirmed the head of the bed and not head of the bed and not employed.	F 323			

Resident #12 was admitted to the facility on

		AND HUMAN SERVICES & MEDICAID SERVICES		¥1	No. /2	FUKIVI	13 1/14/2011 APPROVED .0938-0391
	OF DEFICIENCIÉS F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		445174	B. WIN	G		11/09/2011	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	IAVEN MANOR				S STONEBROOK PLACE NGSPORT, TN 37660		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Mental Disorder, Hy Osteoporosis.  Medical record revirecapitulation order "Alarming Seat Be Medical record revie Post-Fall Assessme revealed the resider Medical record revie March 28, 2011, revresident laying on fl bathroom door(no seat belt alarm, we alarmed when residit wasn't powered or properly, and power Interview on Novem the Director of Nursconfirmed the safety at the time of the fall Resident #22 was a February 17, 2011, Fractured Neck of Feychosis.  Medical record revied dated August 30, 20 at high risk for falls.	ew of the physician's stated March, 2011, revealed elt in W/C (wheelchair)"  ew of the Interdisciplinary ent dated March 28, 2011, and had a history of falls.  ew of a Nurse's Note dated wealed, "staff observed oor on (left) side in front of oil injuriesupon inspection of discovered it had never lent got up from w/c because in. Seat belt placed on resident red on"  siber 8, 2011, at 8:50 a.m., with ing, in the conference room, of device was not functioning I on March 28, 2011.  dmitted to the facility on with diagnoses including	F 3	223			
	dated August 18, 20	ide of bed while pt (patient) in					99

		AND HUMAN SERVICES		N o		APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		445174	B. WING		11/0	9/2011
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO 2035 STONEBROOK PLACE KINGSPORT, TN 37660		SIZU11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 12	F 32	3		
	revealed the reside mat to the exit side pad alarm cord uni	terview with RN (Registered mber 9, 2011, at 8:35 a.m., ent lying on the bed without a of the bed, and the pressure nooked lying on the floor.	1			
	24, 2011, with diag	dmitted to the facility on May noses including Alzheimer Falls, and Fracture of Ribs.				
	(IVIDS) dated Augus	ew of the Minimum Data Set st 23, 2011, revealed the xtensive assistance with	*			
2	risk for falls, the res	ew of the Care Plan dated , revealed the resident was at sident was on the Falling Star t waist restraint was to be e wheelchair.				
	recapitulation Order	ew of the Physician's rs dated November 2011, aist Restraint in W/CFalling				
1	after a falla nev	g Star program revealed v intervention must be ly to assure resident safety"				
	dated October 4, 20 "observed residen October 8, 2011, at	ew of facility documentation 11, at 2:00 a.m., revealed It laying in floor next to bed", 9:20 a.m., "observed or in front of closet", and				

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			No. 7	<b>FOKIV</b>	151/14/2011 APPROVED 0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD	TIPLE CONSTRUCTIO	N	(X3) DATE S	SURVEY
		445174	B. WING			141	09/2011
BROOKI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CIT 2035 STONEBROO KINGSPORT, TN	K PLACE		09/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORR RRECTIVE ACTION SI RENCED TO THE AP DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
	on bottom in floor be Interview with Regist 8, 2011, at 3:20 p.m confirmed no new in place after the falls had not been follow. Observation on Novin the resident's roowheelchair with a so observation reveale between the wheelchair with a so observation reveale between the wheelchair guard and the placed over the whole skirt guard and the placed over the whole stand the back post and continued the back post and continued the secure the levers belt should the should the should the soft we correctly according to the confirmed the soft we correctly according to the should the should the soft we correctly according to the should the s	stered Nurse #2 on November in, at the 400 Nurses' Station, interventions had been put in and the Falling Star program red.  The stered Nurse #2 on November in, at the 400 Nurses' Station, interventions had been put in and the Falling Star program red.  The star program red.	F 32	3			

		AND HUMAN SERVICES			No. //	FORM	6 1/14/2011 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ULTIPLE CONSTRUCTION DING	ı	(X3) DATE S COMPLE	URVEY
		445174	B. WIN	G	-	11/0	9/2011
BROOK	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY 2035 STONEBROOK KINGSPORT, TN	( PLACE	1 100	J. J. Z. G. T.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH ÇORI	R'S PLAN OF CORRE RECTIVE ACTION SH RENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	(MDS) dated Septe resident had severe not steady moving of dependent for toilet assistance with transmedical record revies September 22, 201 restraint to be used	mber 13, 2011, revealed the ely impaired cognitive skills, on and off toilet, totally use, required extensive sfers, and did not walk.  ew of the Care Plan dated 1, revealed "soft waist white in wheelchair. Falling	F3	23			
	Medical record reviet dated November 20 Restraint in W/CF Alarm to alert staff of Medical record reviet April 4, 2011, at 6:30 resident sitting in flowheelchairalarm f	Alarm as ordered"  ew of the Physician's Orders 11, revealed "Soft Waist alling Star programBed of unassisted transfers"  ew of Nurse's Notes dated 0 p.m., revealed "observed or on buttocks in front of					
	August 19, 2011, at "resident observed bathroom"  Interview with the Di November 8, 2011, a Nurses' Station, con was not in the on polalarms are to be on a was left unattended.	rector of Nursing (DON) on at 8:40 a.m., in the 400 firmed the resident's alarm sition on April 4, 2011, and all at all times, and the resident on the commode on August sident required extensive and should not be left					

No. /254 P. 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
		TOTAL TOTAL POST OF THE PARTY O	A. BU	ILDING	G	COMPL	ETED	
NAUE 05.5		445174	B. WI	NG_		111	D9/2011	
BROOKI	ROVIDER OR SUPPLIER	7		20	EET ADDRESS, CITY, STATE, ZIP CODE 035 STONEBROOK PLACE INGSPORT, TN 37660	1 11/	09/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	Observation on Novin front of the 400 Novin front of the 400 Novin front of the 400 Novin front of the wheelchair and look levers.  Interview with Regis 7, 2011, at 4:00 p.m.	vember 7, 2011, at 4:00 p.m., lurses' Station, revealed the chair with a soft walst restraint, ion revealed the straps on the saxle of the wheel of the ned over the wheelchair tilt	F	323	F 332  Corrective action(s) accomplished for residents found to have been affecte.  Resident #19 on November 7, 2011; L. Practical Nurse corrected insulin dose correct dose administrated.  Resident #19 on November 7, 2011; L. Practical Nurse notified Nurse Practition on adverse reactions noted.	d: icensed and the	11/21/2011	
F 332 SS=D	Station, confirmed the soft waist restraint was not applied correctly according to the manufacturer's instructions.  483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.			132	Resident #18 on November 7, 2011; L. Practical Nurse notified Nurse Practition adverse reactions noted.  How other residents having the pote be affected were identified and corresction(s) accomplished:	vember 7, 2011; Licensed fied Nurse Practitioner and snoted.		
	Based on observation review of manufacture interview, the facility administer medication opportunities, resultinate.  The findings included Observation on Noverevealed Licensed Performed an accucion sugar) to resident #1	T is not met as evidenced on, medical record review, rer's instructions, and falled to appropriately ons in three of forty-one in a 7.3% medication error d:  ember 7, 2011, at 4:45 p.m., ractical Nurse (LPN) #3 neck (test to monitor blood 9. Continued observation is blood sugar registered	¥I		Beginning on November 8, 2011 and of the Licensed Nurses were educated by Director of Nursing and/or the Assistant Director of Nursing on the correct wait between inhalers.  Beginning on November 8, 2011 and of the nurses were educated by the Director of on correct charting of a blood glucose by verifying the units of insulin with a seconurse.  Beginning on November 8, 2011 and or the nurses were also educated by the Di Nursing and/or the Assistant Director of on verifying correct dosage of medication administering.  In services will be added to the Licenses orientation packet.	the times  Ingoing or of f Nursing evels and ond  Ingoing rector of f Nursing		

STATEMENT	OF DEFICIENCIES	1000 DD 01-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-			OMB MC	). 0938-0391
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S	
		445174	B. WING	·	4411	00/0044
NAME OF F	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		09/2011
	AVEN MANOR			2036 STONEBROOK PLACE KINGSPORT, TN 37660	•3	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	JOHN DE	COMPLETION DATE
F 332	Continued From pa	ge 16	F 332	F 332 Cont.		
	Medical record review of the November 2011, physician's recapitulation orders revealed "Accuchecks BID (twice a day) with StandardSliding Scale Insulin as follows: Novolin R insulin351-400=12u (units)"  Continued observation revealed LPN #3 prepared an injection of Novolin R insulin. Observation and interview with LPN #3 revealed LPN #3 stated had prepared 12 units of the Novolin R insulin. Continued observation revealed the insulin syringe contained 14 units of Novolin R Insulin. Continued observation revealed LPN #3 entered the resident's room to administer the Insulin, and was asked to observe the amount of Insulin in the			Measures or systematic changes por place to ensure the deficient praction of recur:	ut into ce does	
				Beginning on November 21, 2011; the Manager or Assistant Director of Nu will do random observations of med ensure correct medication and dose a given. The checks will be done twice for ninety days with monthly submis the Quality Assurance Committee will determine the need for future focus.	rsing passes to re being a week sion to	
	syringe and expelle syringe.	ve the amount of Insulin in the d 2 units of insulin from the		Quality Assurance program put in to monitor corrective actions and c the deficient practice will not recur	nsure	
i	amount of insulin pr resident was not cor	I.		The Risk Manager or the Assistant D of Nursing will report overall finding Quality Assurance Committee Meetir (which consists of the Medical Direct Administrator, Director of Nursing, A	s in the ng or,	
}	TO SALLER FLIA MO 90	ember 7, 2011, at 4:57 p.m., ministered Acetaminophen i0 mg (milligrams) to resident		Director of Nursing, Risk Manager, e	tc.)	- 1784 -
	priysician's recapitul	w of the November 2011, ation orders revealed the live Acetaminophen 500 mg				
	interview on Novemb LPN #3, in the hallwa not receive the corre Acetaminophen.	per 7, 2011, at 5:10 p.m., with ay confirmed the resident did ct dosage of the				

CTATEMEN	T OF PERSONNEL	E & MEDIOAID SERVICES			OMB NC	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE 8 GOMPL	SURVEY
111111111111111111111111111111111111111		445174	B. WING _		11/	00/2044
BROOKI	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660		09/2011
(X4) ID PREFIX TAG	LEAGH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
SS=F	Observation on No revealed LPN #4 ar resident #18. Cont LPN #4 administer (bronchodilator aer administered the set Review of the man Combivent reveale were to elapse between to elapse between the set of Combivent (b) #4, at the nurse did not wait two min of Combivent (b) FOOD PROTORE/PREPARE  The facility must (c) Procure food from the considered satisfact authorities; and (c) Store, prepare, ounder sanitary conditions.	ovember 8, 2011, at 8:39 a.m., administering medications to atinued observation revealed red an inhalation of Combivent prosol), waited 25 seconds and second inhalation of Combivent arosol, waited 25 seconds and second inhalation of Combivent and approximately two minutes tween inhalations.  The sing station, confirmed LPN #4 inutes between the inhalations  ROCURE, E/SERVE - SANITARY  The sources approved or coordinate and serve food.	F 371	F 371  Corrective action(s) accomplished residents found to have been affect.  No residents were identified.  How other residents having the policy action(s) accomplished:  On November 8, 2011; the Dietary Minade a check of the kitchen to ensure scoop sizes was being used, the hand policy was being followed, and food stored properly.  Measures or systematic changes purplace to ensure the deficient practice.  Beginning on November 10, 2011 steps.	detential to crective  Manager ethe proper it washing was being was being ut into ce does not ethicken foliately on ing policy, y employee to place to ure the  Dietary random relichen thecks will with ssurance	(1/21/201)
	Based on observation review of the dietary facility failed to ensure proposed followed, failed to proposed to the proposed failed to proposed failed failed to proposed failed fai	tion, review of facility policies, y menus, and interview, the ure food was stored properly, per hand hygiene was prevent ice buildup in the walk at to ensure the proper scoop		future focus.  The Director of Dietary or Dietary Assembly for consists of the Quality A Committee Meeting (which consists of Medical Director, Administrator, Director, Assistant Director of Nursing Manager, etc.)	Assurance of the ector of	. J

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
UND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY
COMPLETED

	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPLI	ETED
NAME OF P	ROVIDER OR SUPPLIER	43174	STREE	ET ADDRESS, CITY, STATE, ZIP O		09/2011
BROOK	HAVEN MANOR		203	5 STONEBROOK PLACE IGSPORT, TN 37660	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 371		ge 18 serving food in dietary.	F 371			
	The findings include			ži.		
	at 11:15 a.m., with dietary department approximately one the floor in the walk style okra, unopened; shakes, unopened; unopened; 1 box bi breast, unopened; unopened; 2 boxes	terview on November 7, 2011, the Dietary Manager, in the revealed the following: and half inch build up of ice on a in freezer; 1 box southerned; 1 box vanilla mighty 1 box vanilla pudding, oneless skinless chicken 2 boxes sweet potatoes, breaded fish nuggets, in the floor in the walk in	T.	*		
	outside door, open dining room, went	vember 7, 2011, at 11:20 a.m., aff #1, entered dietary from an ed and closed the door to the over to a table in dietary and nes covered in plastic wrap e hands.			ži.	
	Infection Control ar	ty policy, Nutritional Services and prevention of ealed, "Do not store food on				
	Interview on Novem with the Dietary Ma be washed prior to	nber 7, 2011, at 11:25 a.m., nager, confirmed hands are to handling food.				
9	Review of the SpreamChicken & Dump cup)"	adsheet of Diets, revealed lings (8 oz)Carrots (1/2				
	Observation on Nov	vember 7, 2011, at 11:45 a.m.,				

No. /254

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/14/2011

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES		O	MB NO. 0938-0391
STATEMEN AND PLAN (	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		445174	B. WING		44/00/0044
BROOK	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP GODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660	11/09/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D RE COMPLETION
F 371	Manager, revealed chicken and dump and served carrots the lunch meal.  Interview on Nove with the Dietary Manager, revealed to the proof.	intrement, with the Dietary If the dietary staff #2 served Illings using a 4 ounce scoop, Is using a 2 ounce scoop during Imber 8, 2011, at 10:00 a.m., Is proper scoop size for the	F 37	Corrective action(s) accomplished for the residents found to have been affected:  Resident #17 on November 8, 2011; Nurse Practitioner signed September and October physician orders.  How other residents having the potential be affected were identified and corrective.	r I to
F 386 SS=D	and the proper second and the proper second and the proper second and the proper second and carrots.  483.40(b) PHYSIC CARE/NOTES/OF The physician must program of care, in treatments, at each of this section; writh notes at each visit; with the exception	lings was an 8 ounce scoop op size for the carrots was a 4 he incorrect scoop sizes had ng the chicken and dumplings IAN VISITS - REVIEW DERS It review the resident's total ocluding medications and n visit required by paragraph (c) e, sign, and date progress and sign and date all orders of influenza and pregumenced	F 386	action(s) accomplished:  Beginning on November 14, 2011; Physici are being educated by the Medical Records Director on the importance of signing orde timely.  Measures or systematic changes put into place to ensure the deficient practice doe recur:  Beginning on November 21, 2011 the Med Records Director or the Assistant Director Nursing will do random checks of physicia orders to ensure orders are being signed tim The checks will be done once a month for significant or the checks will be done once a month for significant or the checks will be done once a month for significant or the checks will be done once a month for significant or the checks will be done once a month for significant or the checks will be done once a month for significant or the checks will be done once a month for significant or the checks will be done once a month for significant or the checks will be done once a month for significant or the checks of the	iens s ts  es not  ical of n nely.
	administered per p policy after an asse  This REQUIREME by: Based on medical review, and intervie two physician's ord	hysician-approved facility essment for contraindications.  NT is not met as evidenced record review, facility policy with facility failed to ensure ers were signed timely for one enty-seven residents		months with monthly submission to the Qu Assurance Committee who will determine to need for further focus.  Quality Assurance program put into place monitor corrective actions and ensure the deficient practice will not recur:  The Director of Nursing or the Assistant Director of Nursing will report overall finds in the Quality Assurance Committee Meetin (which consists of the Medical Director, Administrator, Director of Nursing, Assistan Director of Nursing, Risk Manager, etc.)	ality the ce to e ings

The findings included:

DEPART	TMENT OF HEALTH	AND HUMAN SEKVICES					INI APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		445174	B. WIN	√G		11	/09/2011
	PROVIDER OR SUPPLIER	4	-1.	2035	ADDRESS, CITY, STATE, ZIP STONEBROOK PLACE SSPORT, TN 37660		10012011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 386	Resident #17 was a 11, 2011, with diag Osteoarthritis, and Medical record revirecapitulation order October 2011, revewere unsigned and physician. Continuatevealed two teleph 14, 2011, and Octoby the physician.  Review of the facilitirevealed "Physician"	admitted to the facility on June moses including Hypertension, Congestive Heart Failure.  New of the physician's res for September 2011 and ealed the physician's orders if undated by the treating ed medical record review hone orders, dated September ober 5, 2011, had been signed by policy, Physician Services, cian services include, but are d. Written and signed orders	F	386			
F 441 SS=D	Interview with the A Nursing), on Octobe 400 half nursing sta #17's recapitulation the physician to sign September 2011, no recapitulation order timely, by the preso 483.65 INFECTION SPREAD, LINENS  The facility must est Infection Control Prosafe, sanitary and control provent the confidence of disease and infection Control (a) Infection Control	ADON (Assistant Director of per 8, 2011, at 2:35 p.m., at the pation, confirmed that resident in orders had been flagged for in, but to date, neither nor October 2011, as had been signed and dated cribing physician.  I CONTROL, PREVENT stablish and maintain an regram designed to provide a comfortable environment and development and transmission ction.	F 4	41			

No. 7254 P. 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ILTIPLE CONSTRUCTION	OMB NO. 0938-03	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUIL		(X3) DATE (	
	~~~	445174	B. WIN	3	1	
NAME OF PROVIDER OR SUPPLIER				11/	09/2011	
	HAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP COT 2035 STONEBROOK PLACE KINGSPORT, TN 37660	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Program under whi (1) Investigates, co In the facility; (2) Decides what p should be applied t (3) Maintains a rece actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident. (2) The facility musi communicable dise from direct contact direct contact will the (3) The facility musi hands after each di hand washing is Ind professional practic (c) Linens	ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective effections.  and of Infection lon Control Program esident needs isolation to of infection, the facility must ase or infected skin lesions with residents or their food, if ansmit the disease. I require staff to wash their rect resident contact for which loated by accepted e.	F 4	Corrective action(s) accomplisher residents found to have been affer the Geri-tech on November 8, 201 hand sanitizer by the Assistant Direction on her person and the hand washing policy and use of sanitizer.  How other residents having the pube affected were identified and conscion(s) accomplished:  Beginning on November 09, 2011 at the nursing staff was educated by the Nursing and/or the Assistant Direction the hand washing policy and the sanitizer.  In service will be added to the employientation packet.  Measures or systematic changes pubace to ensure the deficient practice.  Beginning on November 21, 2011 in Beginning on November 21, 2011 in	entive action(s) accomplished for those ents found to have been affected:  eri-tech on November 8, 2011 was given sanitizer by the Assistant Director of ag to have on her person and educated on and washing policy and use of hand ser.  other residents having the potential to exceed were identified and corrective (s) accomplished:  ning on November 09, 2011 and ongoing using staff was educated by the Director of using staff was educated by the Director of using hand washing policy and the use of hand er.  ice will be added to the employee the ensure the deficient practice does not one source the deficient practice does not	
	This REQUIREMEN by: Based on observation			Manager or the Assistant Director or will make random checks of ice pass that the hand washing policy is being The checks will be done twice a more months with monthly submission to Assurance Committee who will detented for future focus.  Quality Assurance program put in monitor corrective actions and ensideficient practice will not recur:  The Director of Nursing or Assistant Nursing will report overall findings in Quality Assurance Committee Meetic consists of the Medical Director, Addresses of the Medical Director, Addresses of Nursing, Assistant Director Nursing, Risk Manager, etc.)	f Nursing ses to ensure g followed.  nth for six the Quality rmine the  to place to sure the  Director of in the ng (which ministrator	

No. 7429 P. 2/2

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	WINDOWN OF WICES			OMB NO	<u>). 0938-0391</u>
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		SURVEY LETED
		445174	B. WIN	IG		00/0044
AMERICAN SOLUTION	NAME OF PROVIDER OR SUPPLIER  BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, 2 2035 STONEBROOK PLACE KINGSPORT, TN 37660		09/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 465 SS=E	Observation on Novon the 100 hallway, (nursing aide assist for four residents. Or revealed the technic the pitchers with los room, and exited with between residents.  Review of facility por Hygiene, dated Seppersonnel shall following the procedures infection to other persistorsuse of Alcocontact with objects the resident"  Interview with the Ganthands between resident the Garihands between residents in the confirmed the Garihands in the confirmed the Garihands in the confirmed the Garihands in the confirmed the c	rember 8, 2011, at 9:00 a.m., revealed the Geri-Tech ant), filling ice water pitchers Continued observation clan went into each room, filled returned the pitchers into the thout sanitizing the hands licy, Handwashing/Hand tember 2005, revealed "all with hand-washing/hand to help prevent the spread of rsonnel, residents and shol-Based Hand Rub ethanol or isopropanolafter in the immediate vicinity of pri-Tech, on November 8, in the 100 Wing hallway, fech had not sanitized the dents.  Is isstant Director of Nursing per 8, 2011, at 9:15 a.m., in any confirmed the Geri-Tech and Infection control practice thands between residents.  JSANITARY/COMFORTABL	F 46	Corrective action(s) accorresidents found to have be No residents were identified. How other residents having the affected were identified action(s) accomplished:  On November 9, 2011 a che restroom was completed by Maintenance and the POC. Those extensive repair whereby till required will be completed a December 20, 2011 to allow proper installation.  Measures or systematic che place to ensure the deficient recur:  Beginning on November 9, 2011 monthly for three months the thereafter with submission to Assurance Committee.	inplished for those een affected:  d.  Ing the potential to and corrective  eck of all resident the Director of enance Assistant and pairs.  Iddress the immediate of all commodes the requiring more ereplacement is by for ordering and anges put into at practice does not enake monthly borns to address ons will be done on quarterly to the Quality  In put into place to and ensure the ecur:  The Maintenance all findings in the effection, Administrator, at Director of	12/20/11
DRM CMS 286	7/00 001 0					

No. /254 PRINTED: 11/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445174 11/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2035 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE" DATE DEFICIENCY) F 465 Continued From page 23 F 490 F 465 11/21/2011 Corrective action(s) accomplished for those This REQUIREMENT is not met as evidenced residents found to have been affected: Based on observation and interview the facility All residents had the potential to be affected. falled to provide a safe and sanitary environment On November 7, 2011 the fire watch policy was for thirty-four resident bathrooms observed. implemented immediately by the Director of Maintenance. The findings included: Observation of thirty-four resident bathrooms on How other residents having the potential to November 7-9, 2011, revealed the following: floor be affected were identified and corrective tiles cracked and missing; the door frames rusty action(s) accomplished: and paint missing; toilet paper rolls missing; holes Beginning on November 7, 2011 the fire watch in the walls; the base of the commodes were policy will stay in effect until the new sprinkler brown with caulk missing, and baseboards were system is inspected and the Department allows loose and in need of repair us to lift the watch. Observation and interview with the Maintenance On November 18, 2011 the Assistant City of Kingsport Fire Marshall inspected the new Director on November 9, 2011, at 8:30 a.m., in system. Also training was done with the the resident bathrooms, confirmed the bathrooms Kingsport Fire Department on the new system. had not been maintained in a safe and sanitary manner and were in need of repair. On November 18, 2011 at approximately 1:15 F 490 483.75 EFFECTIVE F 490 pm per a phone conversation with State Fire ADMINISTRATION/RESIDENT WELL-BEING SS=L Inspector fire watch was lifted for the building. A facility must be administered in a manner that enables it to use its resources effectively and Measures or systematic changes put into place to ensure the deficient practice does not efficiently to attain or maintain the highest

practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to be administered in a manner to maintain the safety of residents by failure to ensure the fire sprinkler system was in The old sprinkler system is being replaced with a new system. As of November 17, 2011 the new system is fully functional and being monitored. We are just waiting on our final inspection from the State.

As of November 18, 2011 any reports on the sprinkler system will be given to the Administrator for signature.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8J5F11

Facility ID: TN8203

if continuation sheet Page 24 of 26

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	OMB NO. 0938-				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY  QQMPLETED		
					} ******		
NAME OF	PROVIDER OR SUPPLIER	445174	B, WING		441	00/2044	
1000	HAVEN MANOR	560 00000	2	EET ADDRESS, CITY, STATE, ZIP CO	DE	09/2011	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		INGSPORT, TN 37660			
TAG	1 (CACO DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	PUALICARE	(X5) COMPLETION DATE	
F 514 SS=D	reliable operating of placed all 161 residence all 161 residence all 161 residence and placed all 161 residence and placed all 161 residence and placed all 161 residence all 161 residence all 161 residence and practice and pra	condition. The facility's failure dents in the facility in all from the likelihood of burns, and death should an ur. The Administrator was nediate Jeopardy on at 4:02 p.m.  Code K-62, related to failing sprinkler system in reliable  Code K-154, related to diing or providing an approved sprinkler system is out of plemented immediately on the pardy. An Allegation of cepted November 8, 2011, and severity of the deficient in the complete of the with accepted professional ces that are complete; and readily accessible; and readily acc	F 490	F 490 cont.  Quality Assurance program put monitor corrective actions and edeficient practice will not recur:  As of November 17, 2011 the new be put on a regular maintenance price in operation with current rethe Maintenance Director or the Maintenance Committee (which considered in the Maintenance Committ	rystem will rogram to regulations. Maintenance the Quality pists of the ping Rich		
r	ervices provided: the	the resident; a record of the					

STATEMEN	T OF DEFICIENCIES	(X1) PRO/MEDITURDING			OMB NO	) <u>. 0938-03</u> 91
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S	BURVEY
		445174	B. WING		1	
NAME OF	PROVIDER OR SUPPLIER	10114	<del></del>		11//	09/2011
	HAVEN MANOR		s	TREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660	Ē	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	T	The state of the s		
PREFIX TAG	1 CONTRACTOR DEPRENCE	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOILDE	COMPLETION DATE
F 514	Continued From pa	ngo 25				1
	transact for pa	ige 25	F 514	4 F 514		i
	and progress notes	5.		2		11/21/2011
	This REQUIREMEI by: Based on medical the facility failed to administration reconstruction twenty-seven resident the findings included the findings include	record review and interview maintain accurate medication rds for one resident (#8) of ents reviewed.  ed:  ew of the Medication ord (MAR) dated November letolazone (Zaroxolyn) 2.5 mg (daily), Edema **HOLD If pressure) > (over) 90**"  ord review of the signed sted July 2011, and November etolazone (Zaroxolyn) and November etola		Corrective action(s) accomplished residents found to have been affect Resident #8 on November 8, 2011; I Practical Nurse corrected MAR and practitioner was notified.  How other residents having the pobe affected were identified and correction(s) accomplished:  On November 09, 2011 the Medical Director was educated by the Director Nursing on ensuring correctness of porders before transcribing orders onto medication administration record.  Measures or systematic changes purplace to ensure the deficient practic recur:  Beginning on November 21, 2011 the Manager or the Assistant Director of will make random checks of medication administration records to ensure order transcribed correctly. The checks will two times a week for ninety days with submission to the Quality Assurance (who will determine the need for future Quality Assurance program put into monitor corrective actions and ensure monitor corrective actions and ensured the property of the control of	ted: Licensed Nurse  Petential to rective  Records or of hysician of the desired	11/21/20[1
	of the Physician Orde	ers and MARs.		deficient practice will not recur:  The Director of Nursing or the Assistate Director of Nursing will report overall in the Quality Assurance Committee M (which consists of the Medical Director Administrator, Director of Nursing, As Director of Nursing, Risk Manager, etc.)	nt findings feeting	